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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW HAMPSHIRE

DARTMOUTH-HITCHCOCK CLINIC, et al.	*	
	*	11-cv-358-SM
v.	*	January 10, 2012
	*	1:40 p.m.
NEW HAMPSHIRE DEPARTMENT OF HEALTH AND HUMAN SERVICES, COMMISSIONER	*	

Day 1, AFTERNOON SESSION
TRANSCRIPT OF MOTION HEARING
BEFORE THE HONORABLE STEVEN J. MCAULIFFE

Appearances:

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I N D E X

BEFORE THE COURT

THE COURT: Mr. O'Connell.

MR. O'CONNELL: Thank you, your Honor. Plaintiffs are calling Frances Gaffney, please.

FRANCES GAFFNEY

having been duly sworn, testified as follows:

THE CLERK: Will you please state your name for the record and spell your last name.

THE WITNESS: My name is Frances Gaffney,. G A F F N E Y, Comeau, C O M E A U.

DIRECT EXAMINATION

BY MR. O'CONNELL:

Q. Where do you live?

A. I live in Lee, New Hampshire.

Q. Are you currently employed?

A. I am.

Q. Where are you employed?

A. I'm employed at Exeter Healthcare.

Q. And what is Exeter Healthcare?

A. Exeter Healthcare is a 28-bed skilled facility that's located on the campus of Exeter Hospital.

Q. What is your position at Exeter Healthcare?

A. I'm the administrator at Exeter Healthcare.

Q. And what types of services are provided at Exeter Healthcare?

A. Exeter Healthcare has four basic types of services they provide. We provide short-term rehab to patients who are leaving the hospital and aren't quite ready to go home either as a result of a surgery or a medical event like a stroke. We provide treatment for medically complicated patients, those patients who may need to have six weeks of antibiotics that they can't take by mouth at home and have to be administered intravenously. We have two dedicated rooms for hospice patients so that patients who aren't able to die at home with their family around them can come to Exeter Healthcare and have their family there as opposed to being in the hospital or at a facility further away. And then we have a program for management of patients on ventilators, whether they're on them long-term permanently or short-term as a result of some acute illness.

Q. What is the current status of Exeter Healthcare?

A. On September 14th, 2011, an announcement was made that Exeter Healthcare would be closing no later than September 30th of 2012.

Q. You indicated that Exeter Healthcare has long-term and short-term patients?

A. We do.

Q. What is the Medicaid status of the long-term patients?

A. The long-term patients that are on ventilators we receive inclusive reimbursement of $585 a day. The patients who are not on ventilators but required long-term --

Q. I asked you a different question. I'm sorry if I confused you. But of the long-term patients how many are Medicaid enrolled?

A. We currently have a census of 11 Medicaid patients, one patient that we recently admitted over the last week who's Medicaid pending who had been in the hospital for 77 days and couldn't be accepted by a facility, so in total it's 12.

Q. How many of the 12 are ventilator dependent?

A. Nine.

Q. And when you say long-term, what is the range of time that those patients have been resident at Exeter Healthcare?

A. Anywhere from one year to ten years.

Q. What is the reason that Exeter Healthcare is being closed?

A. Exeter Healthcare runs a deficit margin. We lose approximately $3 million every year that we're in operation.

Q. And what is the current status of those long-term residents at Exeter Healthcare?

A. All of those residents are currently staying at Exeter Healthcare until facilities are approved by the State of New Hampshire to provide ventilator management or managing long-term complicated Medicaid patients. So the state is currently trying to identify those providers, and then I guess they'll have to try to negotiate a rate. But until that's completed they continue to stay with us.

Q. Are you aware of any other programs in the state of New Hampshire that provide the same type of ventilator support for patients as has been the case at Exeter Healthcare?

A. There's one other facility that I'm aware of that has one ventilator dependent patient. However, the program differs substantially from the program at Exeter Healthcare.

Q. Is there a reason why there are not more providers that provide ventilator services on a long-term basis like Exeter Healthcare?

A. Yes. There used to be a number of them in the state of New Hampshire but they're very intensive in terms of time, staff expertise, and cost. And we were the only -- our program started in 1994 and we are the

only program that has consistently provided care over that course of time. All the other programs have ceased to operate.

Q. From where do you draw patients for the 28 beds that you have at Exeter Healthcare?

A. Primarily from the state of New Hampshire. At times we have referrals from the state of Vermont and Vermont Medicaid would pay us for that care. Southern Maine because of our proximity to the Maine border.

Q. But you do a statewide draw here in New Hampshire?

A. We do.

Q. And you -- are you -- strike that. What is Exeter Healthcare's association with what you referenced as Exeter Hospital?

A. Exeter Hospital is another organization under the Exeter Health Resource Company, we're a healthcare system, and we're located on the campus across the street from the hospital.

Q. Are there other affiliates of the hospital in addition to Exeter Healthcare?

A. Yes, there are. There's Rockingham VNA Hospice, Core Physician Services, Exeter Hospital, Exeter Healthcare and Synergy Health and Fitness.

Q. And Core is what?

A. Core is a physician organization. We employ 125 physicians that serve our primary market, our primary service area.

Q. And together those entities that you just described are under what organization?

A. Exeter Health Resources.

Q. What is the status of your employment upon the closure of Exeter Health Resources?

A. I will not be employed. Once Exeter Healthcare ceases to operate I will no longer have a job.

Q. Are you familiar with the Medicaid reimbursement reductions that occurred in the state from fiscal year 2011 and 2012?

A. I am.

Q. Can you identify for the Court what the year-over-year reduction was in payments that Exeter received in 2011 to 2012? And let me put that in front of you, Ms. Gaffney. I'm putting in front of you Exhibit 64. There is a blowup to your left.

A. Um-hum.

Q. If you look at the total UCC payments, the Court has already heard orientation about this chart, but what is the number for Exeter Hospital total UCC payments last year?

A. $9,889,671.
Q. And payments in fiscal year 2012 are what?
A. Eleven million --
Q. Total UCC payments.
A. Oh, zero. Sorry.
Q. And the amounts of money that Exeter is hoping to save as a result of the closure of Exeter Healthcare is approximately what?
A. $3 million.
Q. Are you involved in the efforts to try and transfer the long-term patients to new facilities?
A. I am. As the licensed administrator at Exeter Healthcare, the responsibility is ultimately mine.
Q. And for what period of time have you been involved in trying to find a replacement facility for the long-term Medicaid patients at Exeter Health Resources?
A. We met with representatives from the state prior to the announcement on September 14th, so probably right after Labor Day we started conversations.
Q. So approximately August or September?
A. Yes.
Q. And to date have any resources in state been identified for the placement of your long-term ventilator dependent patients?

A. No, they have not.

Q. If no program can be found in the state of New Hampshire for these ventilator patients, what are their options?

A. Well, since the announcement of Exeter Healthcare being closed has been made and under Medicare law we're required to give a 60-day notice, so my understanding is that that date is firm. So in the event that we would close and there would be no facility, patients would either have to be placed out of state in, say, Massachusetts or New Jersey where there are facilities or be transferred to hospitals where patients of this type are managed in an intensive care unit because typically you won't find on a regular hospital floor a patient on a ventilator because it is a complicated service.

Q. So in what way would the care change with these ventilator patients from, say, Exeter Health Resources to an ICU or some type of intensive care unit in a hospital?

A. The focus of an acute care hospital is you go in when you're sick and then you want to leave. The longer you stay there's data that shows the more chance you have to get additional illnesses, whether it's problems with your skin -- ventilator patients are at

high risk for developing pneumonia. So they have their place, but for people who are living, dependent on a ventilator, it's important for them to have daily activities that are rehabilitative in nature, social, so that they can get up and participate in their daily routines, which isn't allowed in an acute care hospital in an ICU. At Exeter Healthcare if somebody has a dog, many of our patients have family dogs, children, they come in and they visit, dogs get on the bed. They do what they would do at home. That could never be allowed in a hospital environment.

Q. Have you had occasion to try and place any of your long-term patients in other facilities in the state of New Hampshire?

A. A couple years ago one of our patients who had originally been on a ventilator and we weaned off the ventilator was transferred to Exeter Hospital for an acute illness, and while he was there the family had requested he be placed closer to them because they live in the western part of the state out by Peterborough, and during the two months that that man was in the hospital he was referred to 59 facilities that would have been closer for the family to go visit and none of them would accept him. Actually, one did accept him. He went there for one day and his daughter called us

saying that he was traumatized, he needed to come back, and so we readmitted him knowing that the burden was on the family to try to continue to visit from that far distance.

Q. Is the patient you just referenced still a resident of Exeter Healthcare?

A. He is.

Q. Have you been able to successfully find a placement for him now given that it's going to be closing?

A. No, we have not.

Q. Can you describe for the Court the economics associated for caring for a ventilator dependent patient. For example, what are the costs that Exeter Healthcare incurs for daily care?

A. On average the cost, not the charges, are a thousand dollars a day. We get reimbursed $585 a day.

Q. So there's a $415 difference on a daily basis for these patients?

A. Per patient per day, correct.

Q. How is that difference, that $415 difference per patient per day currently covered at Exeter?

A. The Exeter Health Resource board has year-over-year when they've reviewed budgets decided that the loss of Exeter Healthcare could be offset

within the organization from other parts of the organization that had a positive bottom line. So we basically have been subsidized by Exeter Hospital.

Q. Did the trustees make a different decision given the $9.8 million change in funding for the State of New Hampshire for this fiscal year?

A. They did.

Q. Ms. Gaffney, you were in court this morning when we were talking about other category changes for inpatient, outpatient and those types of reimbursements generally?

A. I was.

Q. Has Exeter gone through a similar exercise as you heard testified to about Lakes to determine what its financial impacts have been by changes in other categories?

A. Yes.

Q. I ask you to look at Exhibit 72 for ID. Do you recognize that document?

A. I do.

Q. Without asking you to go through all of the categories as we did earlier today with another witness, can you simply verify that this is what the institution believes the financial impact has been for the rate reductions referenced on this page?

A. Yes.

MR. O'CONNELL: I'd offer it at this time, your Honor.

THE COURT: Any objection?

MR. O'CONNELL: I'd offer this exhibit, Ms. Smith.

MS. HERRICK: We have no objection.

THE COURT: ID may be stricken on Plaintiffs' 72.

(Plaintiffs' Exhibit 72 admitted.)

Q. And just before we put this away, the total financial impact that Exeter is dealing with for the period 2008 through 2013 is what number?

A. $16,089,710.

Q. And that includes the upper pay limit reduction, does it not?

A. Yes.

Q. If we take that number out, what is the total above that?

A. 13,065,466.

Q. And that's different than -- or independent I wish to say than the $9.8 million that we talked about earlier in the year-over-year change, is it not?

A. Yes, it is.

Q. In addition to the closure of this ventilator

dependent program and the program for the medically complex patients you described, what other changes has Exeter Health Resources, the parent organization, implemented to deal with the financial circumstances we have been discussing?

A. Over the past -- well, in September about 70 individuals were laid off. There were 40 positions that were open that were decided not to fill. There was an adult dental practice that closed. There was a program in place for directors, managers, vice-presidents, executive personnel where goals were set, and then there was discretionary bonus money that was paid at the end of the year. This year, although the money was budgeted to be paid, no dollars were paid out to employees and that equaled about $1.2 million.

Also the health insurance. The contribution that the employees have to put in for their health insurance has increased and the benefits have changed in that there are higher deductibles for the employees when they need services.

Q. Has Core Physicians, the physician practice part of Exeter Health Resources, implemented any changes?

A. They had some staff reductions as well as recently making a decision that Medicaid recipients who

live beyond their service area will not be accepted as new patients into a Core Physician practice.

Q. What is the Exeter primary service area?

A. It's primarily the seacoast, but it goes as far west as Nottingham down towards Plaistow down the 125 corridor. So although it's primarily seacoast, we do catch a number of surrounding towns.

Q. So for example, if some Medicaid patient from the Lakes Region General Hospital primary service care area tried to be treated by a primary care physician in Exeter, would they be accepted or would they not be accepted?

A. They would not be accepted after February 1st of this year.

Q. Can you tell me with regard to the reductions in UPL and DSH payments this year, was any inquiry made from the Department of Health and Human Services to Exeter or Exeter Healthcare as to what impacts those reductions could have on your ventilator dependent program?

A. No, there were not.

Q. Were you aware of any opportunity to provide public comment on a proposed state plan amendment that was geared to deal with the reductions in the payments referenced in Exhibit 63?

A. No, I am not.

Q. Ms. Gaffney, why is Exeter taking the actions that you've described here this afternoon?

A. Because Exeter is facing a substantial decrease in funds available to support programs to the tune of $10 million to date and Exeter Healthcare, having been subsidized for $3 million every year, they just feel that they can't afford to continue to do that and make the organization, the health system viable for the years to come.

Q. Do you believe that within the state of New Hampshire there exists the capacity to take your long-term ventilator dependent patients from Exeter Healthcare into another program?

A. As of today, no, I do not.

MR. O'CONNELL: One second, your Honor. I pass the witness. Thank you, Ms. Gaffney.

THE COURT: Attorney Smith? I'm sorry, Attorney Herrick. Sorry.

CROSS-EXAMINATION

BY MS. HERRICK:

Q. You've said in your testimony that you have eight ventilator units; is that right?

A. We have nine patients that are reimbursed as ventilator dependent patients.

Q. And you said that your reimbursement rate is $400 short of what it costs you to provide those services?

A. $415 per patient per day.

Q. And when you use the word "costs" what are you referring to?

A. The actual cost of services that are provided.

Q. By my calculation 8 or 9 times 400 times 365 days a year would result in about a million-dollar loss; is that right?

A. I haven't done the math.

Q. If I'm correct, you have a $2 million loss or so from the other beds in your facility; right?

A. If your math is correct.

Q. And those beds are not necessarily Medicaid beds, are they?

A. They are all licensed and certified under the Medicaid program.

Q. Many of those patients though are Medicare eligible patients; right?

A. Yes.

Q. And the payment rate for Medicare for your facility changed on October 1st of 2011, didn't it?

A. Correct, it did.

Q. It was reduced about 12 percent or so?

A. The actual reduction to Exeter Healthcare overall was about $25 per patient per day.

Q. Did you tell anyone from the state that the closing of Exeter Healthcare facility was due to the reduction from Medicare?

A. Not that I recall.

Q. Who were you working with at the state in order to place those patients?

A. I spoke last week with Karen Carlton. There's a man by the name of John Martin who's currently in the role that Bob Allers had fulfilled until he left, and Jonathan McCosh.

Q. Exeter Healthcare doesn't provide any general hospital services, does it?

A. Could you define what you mean by general hospital services?

Q. The ones that would be subject to the inpatient and outpatient rates that are being discussed in this trial.

A. No.

Q. The ventilator patients in particular are paying under an atypical nursing home rate; right?

A. Correct.

Q. And none of the reductions that you discussed with Attorney O'Connell had anything to do with the

atypical nursing home rate for ventilator patients, did it?

A. Correct. Not directly.

Q. How would the rate paid for the atypical nursing home be indirectly?

A. Well, because by the state imposing the MET tax the Exeter Hospital is no longer able to subsidize us and the ventilator rate has not been adjusted since -- it's over three years since that rate has been evaluated and we haven't received any change in reimbursement for care for those patients.

Q. So it's the Medicaid Enhancement Tax that is really your issue?

A. It's the issue for the entire organization trying to figure out which services we can continue to try to support that don't have adequate reimbursement for the services we provide.

Q. Now, Attorney O'Connell showed you information about the losses that the Exeter Healthcare system, the regional healthcare, I forget --

A. Exeter Health Resources.

Q. Exeter Health Resources. Those numbers are for Exeter Health Resources; right?

A. Which numbers?

Q. The ones that he showed you on -- I believe

it's still up, Exhibit 72. It's on the screen in front of you. It should be.

A. Um-hum.

Q. Just based on the face of the chart it appears that those are Exeter Health Resources. They are not Exeter Healthcare numbers, are they?

A. No, they are not. I believe these are all Exeter Hospital's numbers.

Q. But you don't know for sure, do you?

A. All the services listed are found in an acute care hospital.

Q. You didn't prepare that exhibit?

A. I've reviewed this exhibit with our financial officer and the attorney.

Q. And when you made the decision to close Exeter Healthcare, you anticipated that it would take up to 12 months to place the residents there, didn't you?

A. That's what we allowed. We are required under law to give a 60-day notice.

Q. Have you spoken to anyone at the state about transitioning some of the patients to Genesis Healthcare?

A. No, I have not.

Q. So you're not aware of a plan that would allow them to be transferred to Genesis?

A. I know Genesis expressed interest, but the state has not revealed to me who the approved providers will be.

Q. Has the state discussed with you potential placement at Crotched Mountain?

A. I know that Crotched Mountain, too, has expressed interest, but I don't know that that's where the state is going to approve any of these patients to be transferred to.

Q. It certainly is possible for the state to have that in place before September of 2012, isn't it?

A. It's possible.

Q. Do you know who Mark Whitney is?

A. I do.

Q. Who is he?

A. He's the vice-president of strategic planning at Exeter.

Q. And he often speaks on behalf of Exeter?

A. He does.

Q. Are you aware that Mr. Whitney said that the cutback decisions were driven by two things, first the change in the Anthem rates, and secondly the change of the MET tax?

A. I'm not familiar with the quote.

MS. HERRICK: May I approach, your Honor?

THE COURT: Anytime, feel free.

MR. O'CONNELL: What document are you showing the witness, please?

MS. HERRICK: This is a press release issued on September 15th, 2011.

MR. O'CONNELL: May I review it?

(Pause.)

A. I've read the highlighted part.

Q. Do you have any reason to doubt that that's a press release issued by Exeter Healthcare?

A. Exeter Health Resources.

Q. Exeter Health Resources?

A. No, I have no reason to doubt it.

Q. And is it -- on the backside of the page, can you read to me what Mr. Whitney said about the reasons for the cutbacks?

A. The entire quote or the part you have highlighted?

Q. The part I have highlighted, please.

A. Okay. Facing as a result of new Anthem contract terms with Exeter Hospital and Core Physicians, along with the state's imposition of ten million in net Medicaid taxes on Exeter Hospital this year.

MS. HERRICK: I have nothing further.

THE COURT: Any redirect?

MR. O'CONNELL: Very briefly, your Honor.

REDIRECT EXAMINATION

BY MR. O'CONNELL:

Q. Ms. Gaffney, with regard to the press release you were just shown, there's a reference to the administration of the MET on a net basis. For 2012, Exhibit 64 suggests that Exeter is going to be paying a Medicaid Enhancement Tax of what amount of money?

A. $11,173,113.

Q. And there would be no UPL or DSH payments made underneath this budget; correct?

A. Correct.

THE COURT: Anything else?

MR. O'CONNELL: No, your Honor.

THE COURT: Thank you, ma'am, you may step down. You're excused. You may call your next witness.

MR. O'CONNELL: Yes. Dr. Philip Sullivan, please.

PHILIP W. SULLIVAN, MD

having been duly sworn, testified as follows:

THE CLERK: Please state your name and spell your last name for the record.

THE WITNESS: Philip with one L, middle initial W, last name Sullivan, S U L L I V A N.

DIRECT EXAMINATION

BY MR. O'CONNELL:

Q. Good afternoon, Dr. Sullivan.

A. Good afternoon, Mr. O'Connell.

Q. Where do you live, sir?

A. I live in Amherst, New Hampshire.

Q. Where are you currently employed?

A. I'm employed at Southern New Hampshire Medical Center in Nashua, New Hampshire.

Q. What is your profession?

A. I am a psychiatrist, an M.D., a medical doctor with advanced training in treating psychiatric illness.

Q. And for what period of time have you been a psychiatrist?

A. I finished my residency in 1987, so about 25 years.

Q. What is your current role with Southern New Hampshire Medical Center?

A. I serve as the medical director for our inpatient behavioral health unit and oversee clinical care within the behavioral health department for our partial psychiatric day program, for our emergency room, and oversee the other physicians who work within the department.

Q. What is the behavioral health unit as part of Southern New Hampshire Medical Center?

A. It's an acute care psychiatric unit where we evaluate, treat, and undergo discharge planning for seriously psychiatrically ill patients, generally patients who are unable to function at home because of their illness or are unsafe in some way, a danger to themselves or to others because of their illness and cannot function except in a structured inpatient hospital environment.

Q. Starting in 2008, how large -- this is the number of bed count -- was the behavioral health unit?

A. At that time we were a 30-bed unit.

Q. And what is it currently?

A. Ten beds.

Q. And are there any current plans for further reduction?

A. That is still on the table. When the Medicaid reductions came down in the summer of 2011 the initial plan was to completely close the unit as quickly as possible. We reduced to ten beds in anticipation of closing. At this point we're in a holding pattern waiting to see whether that's a viable option.

Q. What were the reasons that caused Southern New Hampshire to reduce the size of the program?

A. Because of the sizable deficit that we experienced because of the reduction in Medicaid

payments.

Q. I'd like you to look at what we've been referring to today as Exhibit 63. Would you indicate for the Court the amount of total UCC payments that Southern New Hampshire received in state fiscal year 2011?

A. That's $11,896,946.

Q. And what payments were they to receive, total UCC payments, in 2012?

A. That's zero.

Q. Was the behavioral health unit operating with a positive margin or a negative margin at the time it was reduced?

A. This is not unique to our behavioral health unit. Generally all behavioral health units run at a substantial deficit.

Q. How were the deficits covered before the decision was made to reduce the size that it currently operates under?

A. Because the hospital was able to maintain a positive margin, they subsidized our services.

Q. And what happened this year that caused a change in that willingness to do the subsidy?

A. The substantial deficit that put the hospital into a negative margin.

Q. Now, what size -- strike that. What percent census or percent of the population that would historically be admitted to the BHU were Medicaid patients?

A. Medicaid patients and potentially eligible patients eligible for Medicaid range between 35 and 40 percent.

Q. Would you describe that last phrase you used, potentially eligible for Medicaid? What does that mean?

A. Well, it means at the time they have no insurance at all, and usually by virtue of their mental illness they are poor and have no resources. People who are chronically mentally ill are generally eligible for Medicaid if they are helped with the application process. Generally chronically mentally ill people have functional impairments which make it difficult for them to apply for Medicaid on their own and many of them fall through the cracks.

Q. So if someone presented without insurance at Southern New Hampshire for admittance into the BHU, would you take certain action with regard to Medicaid status?

A. Whenever we admit an uninsured patient who's chronically mentally ill, we help them with the process of applying for Medicaid during their hospitalization.

Q. Have you, sir, as the director of this program tried to calculate the number of Medicaid patients on an annual basis who will not have access to the BHU now that it's ten beds as opposed to 30 beds?

A. Yes, I have.

Q. What is that number, sir?

A. 237 patients per year.

Q. And how is that number calculated?

A. We took the number of admits to the hospital, to the psychiatric unit, multiplied it by the percentage of Medicaid and potentially Medicaid eligible patients for each year, and then subtracted the number for 2012 from the number for 2009.

Q. So if one of these 237 potential patients to the BHU presents at Southern New Hampshire, how will they be treated?

A. Well, they will not all be receiving care under our psychiatric inpatient unit. They will be evaluated in the emergency room, which is a short process which does not involve any treatment and referred either to another hospital, which is difficult because other hospitals are experiencing exactly the same situation and often refuse our patients when we try to refer them, or refer them to outpatient services, which are inadequate to the task of treating a seriously

mentally ill individual in a decompensated state, which they are when they come to the emergency room.

Q. The typical Medicaid patient who was formerly treated at the BHU would get comparable care from an emergency department?

A. Absolutely not.

Q. In what ways would it be different?

A. Emergency room care is just that. It's emergency based. It's usually over a period of several hours. It involves acute stabilization to the point where the patient is safe enough to exit the emergency room. No real care or treatment is provided beyond safety considerations.

Q. With regard to the BHU, what type of care or treatment would you provide that is different than what you just described would happen in an emergency department?

A. Comprehensive care that would include direct one-on-one nursing care, management by nurses of the patient's illness, full psychiatric evaluation, daily meetings with the psychiatrist to provide treatment, and as our process evolves over the course of the stay on the unit, we involve family members through meetings with social workers and psychiatric staff and do comprehensive discharge planning so that the treatment

that is put in place during the inpatient stay can be continued on an outpatient basis.

Q. Are there particular challenges in treating those with mental illness?

A. The challenges are many. Treating someone with a serious mental illness is quite different from treating someone with a medical illness.

Q. In what way?

A. Well, if you're medically ill you generally want to come to the hospital. You know you have something wrong with you and you are actively engaged in seeking care and accepting the recommendations that are given to you.

Just the opposite is true of mentally ill patients. They often don't believe they have an illness. They may be psychotic and think that the voices are controlling them or that the FBI is out to get them, paranoid delusions, that sort of thing. So there's a lot of finesse involved in engaging the patient in the treatment process. Initially many patients don't accept treatment and we have to convince them that they are ill, hold their hand, teach them about their illness, teach them about the treatment that is going to help them, and then initiate that treatment. And that all takes considerable time.

Q. Have you experienced any difficulties at Southern New Hampshire with mentally ill patients attempting to receive care in the emergency department?

A. Yes, we have, and the difficulties in the emergency room have steadily escalated over the last two or three years. We have seen increasing -- because of inadequate treatment in patients feeling frustrated by not getting adequate treatment in the emergency room or exiting the emergency room only to return later that day or in the days that follow, we see them becoming increasingly agitated. We've had a remarkable increase in violence in our emergency room over the last three years. In fact, just two weekends ago police had to be called to the emergency room, not an uncommon occurrence these days, and when they attempted to subdue an agitated patient they had to use a taser. The taser hit the wrong individual. One of our security guards was tasered in the process of police intervening in our ED.

Q. At the time the behavioral health unit was reduced from 30 beds down to ten, what other resources were changed, if any, personnel and physician?

A. Well, the hospital -- reducing the beds on the behavioral health unit, and we also reduced beds on our pediatric unit, reducing those beds was the last resort that the hospital will turn to in an attempt to save

money to address the negative operating margin triggered by the Medicaid reductions. Salaries were frozen. Our pension plan was frozen. Vacation time was reduced for employees. We cut non-clinical programs, funding for the medical library which provides medical resources for our hospital staff, funding to our 55 plus program, which is an outreach program for elderly. Also the hospital decided it could no longer provide the subsidy for our federally qualified health center in Nashua, the Nashua Area Health Center. So that $500,000 subsidy was cut. Only after all of these other measures were taken was consideration given to cutting clinical programs.

Q. And specifically what clinical staff was reduced out of the behavioral health unit?

A. Before we began cutting beds we had a full-time equivalent of 42 individuals working for the psychiatric unit. That included physicians, nurses, social workers, and mental health associates. We're now at a full-time equivalent of 23.

Q. If a patient with mental illness is unable to get a bed at Southern New Hampshire in the behavioral health unit and has private insurance, what options do they have in your service area?

A. They have options that range as far as they can drive or be driven, or an ambulance can take them.

It is relatively easy to admit a patient with commercial insurance to any community hospital that has a psychiatric unit to the freestanding private psychiatric hospital within the state, Hampstead Hospital, or to similar units in hospitals in neighboring states. All of those are options for a patient with commercial insurance.

Q. Conversely, what options do Medicaid patients who would formerly be treated at Southern New Hampshire in the behavioral health unit, what options do they have?

A. Realistically they don't have any options. This is a disadvantage to population who have no advocates, they're disenfranchised. They generally don't have transportation. They don't have financial resources. So going to another town to try and get into a unit in another hospital is usually not an option for them, and when we attempt to transfer people from our emergency room to another hospital because these other hospitals are experiencing exactly the same difficulties that we are, they generally tell us their units are full.

Q. Before the state decided to withdraw its $11.8 million reimbursement for fiscal year 2012, were you consulted by anyone at the Department of Health and

Human Services about the impacts that would have on the unit of the hospital you had responsibility for?

A. No one consulted me.

Q. Were you aware of any public process involving state plan amendment or an opportunity to be heard by the commissioner of Health and Human Services about the impacts for that reduction?

A. The first I heard of it was from our chief financial officer when he told me we were probably going to have to close the psychiatric unit at the beginning of July 2011.

Q. In any event, you were unaware of any process?

A. Totally unaware.

Q. You referenced during your testimony some action taken with regard to the pediatric unit?

A. That is correct.

Q. What has the hospital done with regard to pediatrics?

A. Pediatrics was a separate freestanding eight-bed unit staffed by specialized pediatric nursing staff. As with the behavioral health unit, pediatrics is -- the patients are a high percentage of Medicaid or potentially Medicaid eligible people. So they were running deficits similar to the deficits that we were running on the behavioral health unit. Decision was

made to close that unit and to open two to four pediatric beds on an adult medical/surgical unit, which is arguably a frightening place for a child.

Q. I don't know if you introduced this, but could you describe to the Court what Foundation Medical Partners is?

A. Foundation Medical Partners is the outpatient practice division of Southern New Hampshire Health Services, or Southern New Hampshire Health System. The hospital is one part of that organization. Foundation Medical Partners is the outpatient practice which employs physicians to provide services in the Nashua community.

Q. As a result of the change in funding from the state or Medicaid reimbursement from the state, has Foundation Partners implemented any changes to patients that it will care for and how?

A. Yes, it has. We have not disenrolled all Medicaid patients, but we have decided to close our physician panels to any new Medicaid patients.

Q. How many physicians are currently employed?

A. Over 200.

Q. And so any of those who would have new Medicaid patients would be telling them what?

A. They wouldn't be getting in the door.

Q. And what are the consequences as a general proposition of not -- the Medicaid population not getting that type of preventive care?

A. Well, everyone needs preventive care. Anybody who goes to their doctor on a yearly basis knows that their doctor is concerned about identifying and treating any number of potentially chronic diseases, like diabetes, asthma, hypertension, high blood pressure, cardiac disease, peptic ulcer disease. These are all illnesses that have significant morbidity and even mortality associated with them if they are not identified early and treated. Without access to primary care physicians our Medicaid population will not have these disorders identified early, will not get preventative care, and will end up with more acute illnesses and severe illnesses that may require much more expensive care such as hospitalization.

Q. What options do Medicaid patients have in your primary service area for other primary care that's not associated with the foundation?

A. There is the Dartmouth-Hitchcock Clinic and the practices of St. Joseph's Hospital. I'm not aware of what their policy is at this point about providing care for Medicaid patients. We also have a federally qualified health center, the Nashua Area Health Center,

within the city of Nashua.

Q. So if those two other entities are unable to take on these Medicaid patients that will no longer be able to get care at Foundation Partners, do they have any other options in the primary service area?

A. Only the Nashua Area Health Center, and they have already had very limited access because of the huge number of patients who are trying to access their services.

Q. When is that limitation on new Medicaid patients being enforced?

A. I believe now.

Q. So if a Medicaid patient in the primary service area makes a call to Southern New Hampshire's Foundation Partners, they will not be seen?

A. Correct.

Q. Would you please look at Exhibit 82 for ID. Dr. Sullivan, do you recognize Exhibit 82?

A. I do.

Q. Would you describe for the Court what it represents?

A. This is a summary of the Medicaid rate reductions which have taken place since 2008 for Southern New Hampshire Medical Center.

Q. These are the same -- generally speaking, the

same categories that you've heard testimony about by previous witnesses?

A. That is correct.

Q. And this is the impact on Southern New Hampshire Medical Center?

A. Specifically, yes.

Q. Okay. And if you look at the total line across from the period 2008 until 2013, what does that total line represent, sir?

A. That represents the --

Q. What is that number? I'm sorry, just read it for the record.

A. The number $21,218,280.

Q. And that includes the upper payment limit reduction. What if we were to not count that, what is the number right above that on total?

A. That would bring us down to $15,022,442.

MR. O'CONNELL: Your Honor, I'd offer 82 and ask that the ID be stricken.

MS. LOMBARDI: No objection.

THE COURT: ID may be stricken on Plaintiffs' 82.

(Plaintiffs' Exhibit 82 admitted.)

Q. Dr. Sullivan, given the implications on patients that you've described today, why are you at

Southern New Hampshire taking the actions that you've described?

A. Well, although we are a nonprofit hospital, it's still a business and no business can operate for any length of time with a negative margin. Services have to be cut or else the hospital can't pay its bills and cannot borrow money because its bond ratings are reduced.

MR. O'CONNELL: Thank you.

THE COURT: Thank you, Mr. O'Connell. Attorney Lombardi, you're taking the witness?

MS. LOMBARDI: Yes.

CROSS-EXAMINATION

BY MS. LOMBARDI:

Q. Good afternoon, Dr. Sullivan. I'm Laura Lombardi. I have a few questions for you.

A. Good afternoon.

Q. You testified earlier about increasing difficulties in the ER over the last two to three years; correct?

A. That is correct.

Q. And those difficulties occurred before the decision was made to cut the beds, the number of beds in the behavioral health unit; correct?

A. We had already started bed reductions at that

point. We had reduced from 30 beds to 18 beds in the spring of 2009.

Q. And your utilization rates, you testified that you cut your capacity from 28 beds to 10 beds. So actually now you're saying from 18 beds to 10 beds; correct?

A. The cut was -- in July of 2011 was from 18 to 10. But that was part of a cumulative cut over a period of two years.

Q. So before these changes, you testified the change -- the reductions between 2011 and 2012, you had already cut beds prior to that time; correct?

A. Although this was not the only factor, the rate reductions that Attorney O'Connell just questioned me about had something to do with that.

Q. And Medicaid patients are the smallest population of patients in the behavioral health unit; correct?

A. They're about 25 -- Medicaid is 25 percent and uninsured is about 14 percent.

Q. And the behavioral health unit is still taking Medicaid patients; correct?

A. Of course. Of course we are.

Q. So if Medicaid beds are available, those patients are not being turned away?

A. That is correct.
Q. And if a bed is not available, there are other facilities in the state that have beds available for those patients; correct?
A. Not always.
Q. But you don't know that personally?
A. Well, I know from personal experience as a supervisor for the emergency room the frustration that we experience trying to admit patients to those beds and they are considerable. Patients -- we often have to work out safety plans for patients to send them home rather than send them to a hospital and hope that they will get the care that they need on an outpatient basis, which is problematic because waiting lists are frequently long for outpatient evaluation and treatment.
Q. But if a patient does need an inpatient bed, generally there is a facility in the state that has a bed available for them; correct?
A. No.
Q. No? You testified earlier about Foundation Medical Partners closing their panels to any new Medicaid patients; correct?
A. Um-hum.
Q. But there are still primary care physicians in the Nashua area that are still taking Medicaid patients;

correct?

A. I don't know the answer to that question.

Q. But there is a federally qualified healthcare center that takes the Medicaid patients?

A. Correct, the Nashua Area Health Center.

Q. And your hospital is a member of the New Hampshire Hospital Association; correct?

A. Yes, it is.

Q. And New Hampshire Healthcare -- I'm sorry, the New Hampshire Hospital Association keeps you informed about upcoming changes to reimbursement rates in terms of budget changes?

A. I believe they inform our administration. They don't inform me personally.

Q. But that association does lobbying on your hospital's behalf?

A. Yes, they do.

MS. LOMBARDI: I have no further questions.

THE COURT: Any redirect?

MR. O'CONNELL: Nothing further, your Honor.

THE COURT: Thank you, Dr. Sullivan. You're excused.

MR. O'CONNELL: Next witness is Jill Batty, please.

JILL BATTY

having been duly sworn, testified as follows:

THE CLERK: Would you please state your name and spell your last name for the record.

THE WITNESS: Jill Batty, B A T T Y.

DIRECT EXAMINATION

BY MS. O'CONNELL:

Q. Ms. Batty, where do you live?

A. I live in Keene, New Hampshire.

Q. Where are you employed?

A. Cheshire Medical Center in Keene.

Q. And what's your position with Cheshire?

A. I'm the chief financial officer.

Q. How long have you been the chief financial officer at Cheshire?

A. Seven years.

Q. And how long have you been involved in healthcare administration?

A. 25 years.

Q. Would you describe for the Court generally what Cheshire Medical Center is?

A. Cheshire Medical Center is an acute care hospital with 169 licensed beds. We have acute inpatient and outpatient services and we are working in partnership with Dartmouth-Hitchcock Keene Physician

Practice under our joint operating agreement, and we are the only provider of acute care services in Cheshire County.

Q. Does that mean you're really the only hospital in Cheshire County?

A. We are the only hospital.

Q. And do you serve Medicaid patients?

A. We do.

Q. Approximately what percent of the Medicaid -- strike that. Would you identify for the Court what the mission of Cheshire Medical Center is?

A. We have a mission of promoting community health in Cheshire County. We operate under Vision 2020, which is about making Cheshire County the healthiest community in the nation by 2020. That involves providing appropriate acute and preventive services for our population, but also promoting health for the general population.

Q. Do you have any specific designations in the Cheshire Medical Center?

A. We are designated as a world referral center under the Medicare program, which basically represents the fact that we have a specialized medical practice in our community that is unique in a rural environment and offers some special reimbursement opportunities under

the Medicare program. And we're also designated as a Medicare dependent hospital, which means our inpatient volume is highly dependent on Medicare. Over 60 percent of our new patients are Medicare patients.

Q. What does that mean about the population you serve?

A. Well, we have an elderly population in Cheshire County, and I guess that would summarize it.

Q. Now, do you -- or have you ever under the mission you just described made any distinction on services you would provide based on payer status?

A. No, we have not.

Q. Have you had to confront a change to that policy because of circumstances?

A. We have. We've always had a very open environment to accept patients in our organization. Because we are responsible for community health and having the services available for our primary service area community, we are limiting access to our services for residents outside of that primary service area.

Q. What specific limitations are you imposing?

A. At present we have closed our physician practices for accepting new -- our primary care practices for accepting new patients who are covered by Medicaid or do not have insurance. So if they live

outside of our primary service area, they cannot begin receiving care from our primary care physicians.

Q. Your primary service area includes what?

A. Cheshire County less the towns of Dublin, Jaffrey and Rindge. So all Cheshire County except for those three communities.

Q. Are you familiar with the year-over-year financial impact of the state's funding decisions from fiscal year 2011 to 2012?

A. I am.

Q. Would you describe for the Court the impact at Cheshire Medical Center -- strike that out. What was the total UCC payment that Cheshire received in 2011?

A. $6,454,494.

Q. And in 2012 you received what?

A. Zero.

Q. What in addition to what you've described are you doing at Cheshire Medical Center to deal with that loss of funding year-over-year?

A. Year-over-year not only for this loss of funding but for the rate reductions that I'm sure we'll talk about, we have seen our operating margin decline year-over-year at Cheshire Medical Center. We've been really focused on trying to be able to maintain our services and meet our mission, so we've accepted

declines in our operating margin versus cutting back on services.

For this particular year our primary focus has been on reducing the costs within our control. We had no wage increases. We eliminated our discretionary match on our employees' pension contributions and we eliminated a short-term disability program for employees.

And then we've also been very focused on managing our staffing level, making sure that our staff are absolutely as productive as possible. We've pretty much reached the end of that path. We are somewhere between the 25th and 30th percentile of expense per case, which means we're very low for organizations of our type. At this point our only options are service reduction in order to meet these reduced reimbursements.

Q. If the limitations and actions you've described are interdictions during the next 12 months, what other options is Cheshire considering as far as service limitations?

A. We have an inpatient psychiatric unit. It is 18 beds, and that will probably be our next step, is to close that unit similar to this decision by Southern New Hampshire.

We are considering limiting access to -- our

first line of access has been elimination of new non-primary service area residents to our primary care practices. We may have to choose to discharge existing patients in our primary care practices who either don't have insurance or covered by Medicaid if they live outside our service area.

We've initially taken only approaches with primary care access. Our next level on that would be to discontinue accepting specialty referrals for residents outside our primary service area. Particularly in high cost practices that have like high drug cost or high medical intervention practices or oncology practices, both medical and radiation oncology, and rheumatology which is treated with a lot of drug interventions and allergy, are our primary area of focus where we are likely to close access for residents outside our service area.

Q. So with regard to possible changes to service in the future, what do you believe the impact would be on Medicaid patients?

A. In the inpatient psychiatric unit we have about 180 discharges per year that are Medicaid. For the specialty referrals for Medicaid we have around 75 Medicaid patients per year coming from outside our service area, those specific practices, and we currently

have 400 Medicaid patients enrolled in our primary care practice who live outside our primary service area. So it all adds up to be around 625 patients affected.

Q. Is that for things that have been implemented or that could be?

A. No, those will be implemented. As far as what's been implemented, we've had the policy in place of not accepting the out of area primary care for three months, and at the rate we're going it's about 50 patients a year. Half of those currently have Medicaid, the other half are uninsured. I'm not certain whether or not they might have been qualified for Medicaid, but they don't have insurance and we're not accepting those either. So 25 we know are affected.

Q. And that could grow to that 600 number if you implement the changes that you've described that are being considered?

A. Correct.

Q. Were you aware of any process by the Department of Health and Human Services to assess the impact to Cheshire -- actually the Medicaid patients in connection with the reduction of the UPL patient payments?

A. No.

Q. Were you consulted by anyone in the department

about what the impacts would be at any time?

A. No.

Q. Are you aware of any state -- public process associated with state plan amendments with regard to the reductions of UPL before they are implemented?

A. No, I am not.

Q. I'd ask you to look at Exhibit 69 marked for ID. Ms. Batty, do you recognize that exhibit?

A. I do.

Q. What is it?

A. It's a summary of the impact of the rate reductions since 2008 projected forward to 2013 for Cheshire Medical Center.

Q. Did you compile this information?

A. I did.

Q. And similarly, does it capture the rate reductions we've heard other -- impact Cheshire Medical Center for rate reductions by categories listed on the left?

A. Yes.

Q. And what are the total -- what is the total financial impact for the rate reductions for 2008 through 2013 without including overpayment amount?

A. $11,910,711.

Q. As a practical matter what does that mean to

Cheshire?

A. We're a $150 million organization per year, and if you look at the number there for the most recent -- well, since 2010 that's two and a half million dollars per year reduction in our revenue. So we've operated with a margin that is less than that for each of those years, and so essentially it has eliminated any opportunity to have an operating margin, which we then -- the operating margin is what we reinvest in our facilities and in our programs and our people, and that's really where the cuts are coming.

Q. With regard to the category cuts referenced in Exhibit 69, were you aware of any public process connected with state plan amendments to effect these changes?

A. No.

MR. O'CONNELL: Your Honor, I'd offer Exhibit 69.

THE COURT: Any objection?

MS. LOMBARDI: No objection.

THE COURT: ID may be stricken on Plaintiffs' 69.

(Plaintiffs' Exhibit 69 admitted.)

MR. O'CONNELL: I have no further questions.

THE COURT: I have a question. Is there

somewhere an expression of these rate reductions in terms of like percentages and comparatives?

MR. O'CONNELL: Only with regard to inpatient, outpatient and family practice. Those are in the declarations. Not for these specific categories, your Honor.

THE COURT: How were they accomplished? Were they accomplished by percentage rate, reductions of rates?

MR. O'CONNELL: Oh, I'm sorry. Yes, with regard to -- well, let me turn to my partner, Mr. MacDonald, who knows the details of some of this.

MR. MacDONALD: Your Honor, in the outpatient reduction there was a 33 percent more or less rate reduction which took place in November of 2008. On the inpatient rates there was a ten percent rate reduction which took place on November 2008. The other rate reductions in the case are not those kind of across-the-board cuts, but I think you'll hear testimony on what they were as a function of the total amount that's being paid.

THE COURT: Thank you, appreciate it.

MR. O'CONNELL: Your Honor had asked us to pay attention to (13)(A) issues and the witnesses tomorrow will be doing that. Today they're appearing about

impacts. Unfortunately, that was the way we had organized the day and we will put up some of that tomorrow.

THE COURT: Okay, appreciate it. Attorney Lombardi?

CROSS-EXAMINATION

BY MS. LOMBARDI:

Q. Good afternoon. I believe you testified that your hospital serves -- approximately 60 percent of the patients are Medicare; is that correct?

A. On the inpatient side, that's correct.

Q. On the inpatient side. And with regard to Medicaid, your declaration indicates that only 5.8 percent of the medical center's total revenue comes from Medicaid; is that correct?

A. I believe it's actually slightly lower than that, but yes, that's right.

Q. And you did not expect to make a profit from treating Medicaid patients; correct?

A. That's correct.

Q. If you could turn to Plaintiffs' Exhibit 69?

A. I have it.

Q. That you just testified to about the losses that you claim that Cheshire Medical Center has experienced. The third line down, Revenue Code 510, you

have that listed as a rate reduction. That wasn't essentially a rate reduction. Was it instead a -- it was an improper billing practice that was corrected; is that correct?

A. Well, no, I don't believe so. It was a change in policy by the Medicaid program as to how they would pay for provider based physician practices. The hospitals that were affected by this have been following Medicare guidelines about provider based practices. Cheshire was one of those providers, and Medicaid made basically a unilateral change in policy about payment which resulted in this reduction.

Q. And it had to do with the way that you reported, not necessarily a reduction in rates; correct?

A. Well, prior to that we were receiving a higher payment for physician based services that were provided to Medicaid patients and at the end of the change in policy we were receiving a million dollars less.

Q. And you also list the upper payment limit as a rate reduction over the three years of 2011, '12 and '13. The upper payment limit, wasn't that in fact a one-time payment made based on the fact that there are funds available for a one year's time?

A. The state presented the upper payment limit to the hospitals with the information for us to understand

that it was an upper payment limit, payment one time in 2010. We don't know what prior payment -- prior DSH/MET reimbursement payments were based on. The calculation details were not shared with us. So I can't speak to whether or not prior period payments were associated with upper payment limits.

The administration of the MET/DSH program have put certain requirements on the state as to how the payments are calculated and processed, and we know that in 2010 in order for them to be processed in the way that they were -- they had to include an upper payment limit payment to the different providers. We would assume that since the payment levels were similar in 2010 as the prior years, that the methodology would have included an upper payment limit calculation, but that was not shared with us.

Q. But you're not as familiar with this area. You're not familiar with the difference between DSH payment and upper payment limit?

A. As familiar as -- I'm not sure --

Q. As perhaps other witnesses who could testify to that issue?

A. I don't know. I feel pretty familiar with it.

Q. But it was a one-time payment. It was not a DSH payment, it was a one-time upper payment limit

payment made in 2010?

A. That's how it's been presented to us recently.

Q. And you testified that physician panels have been closed to new Medicaid patients coming in from outside your service area; is that correct?

A. Correct.

Q. There are other providers in those areas of the state who do still accept Medicaid patients; correct?

A. I don't know that. Probably. I don't know. I will just state we don't have a federally qualified healthcare center in the Monadnock Region, so that sort of last safety net provider is not available to the residents of our primary or secondary service area, and the ones that are being refused by Cheshire/ Dartmouth-Hitchcock concurrently are in a secondary service area and don't have access to another federally qualified healthcare center.

Q. And your hospital is a member of the New Hampshire Hospital Association?

A. Yes.

Q. And they lobby on your behalf?

A. Yes, they do.

MS. LOMBARDI: I have no further questions.

THE COURT: Any redirect?

MR. O'CONNELL: Yes, your Honor, briefly.

REDIRECT EXAMINATION

BY MR. O'CONNELL:

Q. Now, Ms. Batty, you were asked questions about UPL and whether it was a one-time payment or not. I want to clarify the record. Are you aware that on -- that in 2010 with an effective date of November 19, 2010, two years ago, the state issued a state plan which said that the UPL would be an annual payment? Are you aware of that fact?

A. I have seen that in correspondence from the Hospital Association.

Q. And there was a similar document, SPA, filed with the same effective date for inpatient rates; isn't that true?

A. Yes.

Q. As you sit here today, you haven't seen this to speak about it; is that fair to say?

A. I'm sorry?

Q. You haven't studied this --

A. No, I have not.

Q. -- to give the Court informed testimony about all those details; is that fair to say?

A. No, that's correct.

Q. Okay. But it is true that if the state amends

its state plan amendment to say it's going to make a certain payment, it's got to make that payment unless it amends the plan; isn't that true?

A. It's my understanding.

MR. O'CONNELL: Nothing further.

MS. LOMBARDI: Thank you, ma'am.

THE COURT: Thank you, ma'am. Why don't we take a brief break. Ten minutes.

(Recess taken.)

THE COURT: Mr. O'Connell.

MR. O'CONNELL: Thank you, your Honor. We call John Marzinzik.

JOHN MARZINZIK

having been duly sworn, testified as follows:

THE CLERK: Would you please state your name and spell your last name for the record.

THE WITNESS: John, J O H N, Marzinzik, M A R Z I N Z I K.

DIRECT EXAMINATION

BY MR. O'CONNELL:

Q. Good afternoon, Mr. Marzinzik.

A. Good afternoon.

Q. Where do you live, sir?

A. I live in Elliot, Maine.

Q. Where are you employed?

A. At Frisbie Memorial Hospital in Rochester, New Hampshire.

Q. And what is your position at Frisbie Memorial Hospital?

A. I am the vice president of finance and chief financial officer.

Q. And what do your duties and responsibilities include in that position at Frisbie?

A. I oversee all of the financial applications of the hospital, handle all the bank business, investment portfolios. I oversee all the facility's plant maintenance, safety. I'm also corporate compliance officer.

Q. Could you describe Frisbie for the Court?

A. Frisbie is a small acute care general hospital licensed for 112 beds. We also have a specialty unit for geriatric psychiatry which is a ten-bed unit.

Q. What is its primary service area?

A. Primary service area is the Rochester, Farmington, and Milton area.

Q. And what's its extended primary service area?

A. Through Somersworth, the Berwicks, Barrington.

Q. On the easel in front of you is a table that we used -- we used it once earlier today from Exhibit 50, and it's the state's calculation of the

Medicaid population. Is the area located for Rochester, is that where Frisbie's extended service area is?

A. Yes, it is.

Q. And for the record, what is the percent of the total population that's Medicaid enrolled in Rochester?

A. 16 percent.

Q. And the total number is what?

A. 7,238 Medicaid patients.

Q. What does that suggest to you about the general demographics of that primary service area?

A. It is very much a blue collar community. They have been hit by Cabletron leaving, Thompson Center Arms going out. They have had -- it's a tough economic community.

Q. How long have you been there?

A. I have been there for 19 years in July.

Q. How long have you been involved in healthcare administration?

A. Since '77, so 34 years. 33 years.

Q. What is the mission of Frisbie Memorial Hospital?

A. To provide safe, effective, efficient, equitable, timely patient-centered care to everybody in the community.

Q. Has anything changed or made changes as a

result of funding decisions by the State of New Hampshire?

A. Unfortunately, yes, it has.

Q. Would you describe, please, what you're planning for at Frisbie?

A. Because of the cuts that we are now experiencing with Medicaid, specifically the Medicaid Enhancement Tax that we just had to pay our $4 million, we have had to change our charity care policy. Previously it was 300 percent covered in full. It is now down to 200 percent with a sliding fee scale, which we have never done historically.

We have had to change our staffing emergency room which will be effective in March. We are actually going from having three full-time physicians onboard 24 hours down to two.

We are capping our primary care adult services on our employed physicians at a seven percent level. We've looked at what we have for volumes in each practice. We've decided that seven percent is about as high as we can go and still grandfather in existing patients, which means that we are closing six providers in the community leaving only three open for potentially new patients.

We have had to make the decision that we

cannot -- we can no longer support a thoracic program at the hospital and have notified the physician that we will not be renewing his contract. So that Medicaid patients seeking thoracic surgery -- or thoracic services in Rochester will now have to seek services somewhere else.

We had a -- our oncologist was traveling up to Huggins in Wolfeboro a couple times a month to see the patients up there so they wouldn't have to travel. We've had to stop that as well and he's now home-based at Frisbie. They will either seek services elsewhere or they'll now have to drive the hour to come down and see the doc down here.

Q. In the 19 years that you've been at Frisbie, have you ever previously determined what services would be provided to a patient based on payer class?

A. When I first got to Frisbie in '93, I was coming over from Exeter Hospital, where I had worked for five and a half years before that. Frisbie was and still is a very tough community. It is not well-endowed in many senses. Working with my staff down in the ED it was pretty obvious that the way that they treated patients was not equitable. On every patient wristband they had a big mark as to what they had for financial class, and it was not a surprise that Medicaid and

self-pay patients were treated differently than the others.

Within the first week I had those removed. I had the financial class taken off the patient's sticker which is on the face sheet of all the charts to the chagrin of many of the physicians who didn't like it, but that's because we believed strongly at the time, and still do, that regardless of your ability to pay, you should be treated the same. And to put hospitals in the position today that we have to start making economic decisions based on whether they have Medicaid or self-pay patients, whether they have any coverage at all, is wrong. You're hurting patients that you don't see, that you don't hear from, and it's wrong.

Q. Are you familiar with the changes in financing for the State of New Hampshire from state fiscal year '11 to '12?

A. Yes, sir, I am.

Q. Would you summarize for the Court the total amount of UCC payments, uncompensated care payments, that Frisbie Memorial Hospital received in 2011?

A. $8,181,669.

Q. And are you scheduled to get anything in this fiscal year?

A. No, sir, we're not.

Q. What about the next fiscal year?
A. No, sir.
Q. What have you done to deal with that loss of payment in addition to what you've described?
A. We have gone through cost reductions on contracts. We have outsourced all of our facility maintenance housekeeping staff. We have reduced the staffing on all of our med/surg floors. We have changed group buying services from one to the other, which causes some problems internally, but there are some savings that -- enforced savings that will come out of that. As I mentioned, the killing of the thoracic program.
Q. Can I turn your attention to the capping of the primary care practices that you described?
A. Yes.
Q. Have you tried to calculate the number of Medicaid patients you believe will be impacted by that decision?
A. Looking at just the last six months and trying to identify those adult acute care patients coming in to our primary care practices, we're probably talking about 300 new Medicaid patients a year that are going to have to find services elsewhere.
Q. And what specific services will they not be

able to get through Frisbie?

A. You get a sore throat, you now end up going to the ED. You've got an ear infection, it's the ED. You go in and they're going to treat you as the acute visit that it is. It's not that they're going to give you a 30-day prescription. They're going to give you enough medication to last you 24, 48 hours with the instruction to go see a primary care physician. So it's not long-term treatment of an illness, it is the acute episodic illness that they'll treat, and they'll turn them out into the market.

Q. Sir, before the total of uncompensated care payments were taken out of the budget, were you part of any process run by the State of New Hampshire to assess the impacts that that loss of funding would have at Frisbie?

A. No.

Q. Did anybody from the Department of Health and Human Services make an inquiry at Frisbie about what the impacts would be for Medicaid patients by their reduced funding?

A. No, sir.

Q. Are you aware of any analysis done by the State of New Hampshire to determine how access for Medicaid patients would be impacted by the loss of the

$130 million for these ten hospitals?

A. No, sir.

Q. Would you look at the exhibit that's in front of you, sir, which has been marked as Exhibit 75 for ID. Do you recognize that document?

A. Yes, I do.

Q. What is it?

A. Those are the reductions by category for Frisbie for years '08 to 2000, projected '13.

Q. There are three categories identified for which there is some financial impact at Frisbie?

A. Yes.

Q. And these are the same categories that have been discussed in other testimony today?

A. Yes.

Q. With regard to the inpatient rates -- well, let me just summarize. With regard to those three categories identified on this Exhibit 75, what is the total impact for the period 2008 through 2013?

A. Inclusive of the projected upper payment limit it was 15,935,587.

Q. Okay, and if you exclude the upper payment limit which is factored in Exhibit 63 and 64, what is the total impact at Frisbie?

A. $11,611,732.

Q. With regard to these category cuts, were you aware of any public process for state plan amendments to assess the impact of those reductions at Frisbie?

A. Not that I know of.

Q. Were you aware of any assessment by the State of New Hampshire to determine what the impacts would be at Frisbie for those categorical cuts?

A. No.

Q. Mr. Marzinzik, what else is on the table for consideration at Frisbie in the event that changes you have made already are not sufficient to deal with the financial circumstance you've described?

A. We have to go back and look at whether or not we're going to be talking layoffs again. Whether we will be eliminating more services at the hospital, whether we can afford to keep all practices open, the times we do. It's a general across-the-board slash and burn at that point.

I mean, it is not that we haven't already -- when they arbitrarily reduced the rates back in '08, '09, at that point in time when they put us in the position, we had to go borrow money from our line of credit for the first time in 18 years; that we had at that point laid off 25 people, reduced the hours of another 106, froze all wages for over a year. We

stopped the funding of the 403(b), our pension plan, for our staff. We outsourced people then.

We recovered enough over the year to pay our bills. We were forced -- we went into technical default on our bonds. We have since over this past year come out of that technical default. But these payments, we can't afford these kind of -- it will put us back in technical default again.

Q. What are the implications of a technical default?

A. Because of the nature of the bond agreement that we have, it's called a swap agreement, that if we go into technical default, we have to fund what they call the mark to mark, the variability of the bond's collateral if you will. We will need to put $6.8 million into Bank of America's bank as collateral. By doing that, it takes our ability to use those funds for any emergency that we have out of play. It is not available to us.

Q. So in addition to the lack of the funding, you have money that you can't touch for servicing obligations; is that a fair statement?

A. That's correct.

Q. Why are you doing all of the things that you've described here today?

A. We feel very strongly about our community. When we did an addition to the building in 2008 to modernize the facilities we offered to the community, we went all private rooms for efficiency reasons, if nothing else, which we do not charge any higher premium for the private room to any patient. Again, to be treated the same, with the same dignity and respect that we do every day. And we worked hard at making sure that every patient that comes in our doors are treated the same, the same respect. We're polite.

So that it's an incredibly friendly hospital and that is what we've maintained, and we try to keep it as part of the community so the community feels very welcome, whether they're visiting patients, whether they're coming in for lunch, whether they're just coming in to visit somebody or shop in the gift shop. We try to make it and be a very interactive part of the community. We've had those goals. We've built a strong facility. We have a check and balance sheet. We have done some amazing things for our community and we're very dedicated to our community, and that's being torn apart.

Q. What's necessary in order to reverse the decisions that you've made?

A. If the state would adequately fund their share

for just their patients. We no longer have the ability to cost shift. When the state is paying less than what it costs -- if I buy a pill for a dollar, they're paying me 50 cents. So somebody else has to pay that extra 50 cents.

Historically, you go back 10 or 15 years and there was maneuverability within the negotiation of the commercial insurance contracts, who probably paid $1.30 for that pill to help fund those patients that couldn't afford it. It was their way of paying part of your uncompensated care and your bad debts in the community.

Contracts today are capped. So we're allowed maybe a three to a four percent rate increase that we can pass on to the insurance companies. Anything else we eat. We have to absorb it into our system.

The subsidy that we pay for our employed physicians, we subsidize our employed physicians to -- in this past fiscal year ending 9/30/11 some $890,000, and that's not including any fringe benefits for the staff. That's just direct costs to those practices. That's an $890,000 loss which we absorb and really fund through the hospital. In the end it's just one pot of money, and however you divide it up and toss it back and forth, the bottom line is the bottom line.

MR. O'CONNELL: I have no further questions.

THE COURT: I have a question. I'm not sure I can even articulate it properly, but these numbers -- I asked you about the percentage rates, but I assume what you're driving at here is that the reduction in rates applicable to Medicaid patients is causing this problem, but you always throw in the tax, the MET. That's not technically a Medicaid reimbursement rate, is it?

MR. O'CONNELL: I can address that to the Court --

THE COURT: Please. Thank you.

MR. O'CONNELL: You're right to observe that they're related, but they are distinct. The projected MET still has to be paid. It used to be offset by payments, and so now that's just a revenue payment on the bottom line that's --

THE COURT: It's a tax.

MR. O'CONNELL: It's an old tax.

THE COURT: Used to be reimbursed but now it's collected.

MR. O'CONNELL: It used to be neutral.

Q. In fact, Mr. Marzinzik, would you explain to the Court from 1993 until 2010, what was the impact on hospitals financially for payment of the MET?

A. There was zero impact.

Q. Could you describe why?

A. Certainly. The way the methodology worked, and it goes back to a letter that the Senate gave to the Hospital Association, said that we have a way of getting additional federal funds on the state budget, but it is our intent to hold you harmless, and I think that letter is public information.

The way it would work is they would determine what their tax is going to be and our net patient service revenue, which they very loosely defined in those days. It didn't matter because we tried to help the state get it as high as possible so they would get more matching funds. They would tax the hospital in theory, but it always turned out that at the same time once they determined what the tax was going to be, they would make a determination as to what the DSH payment, the disproportionate share payment, was to the hospitals and, lo and behold, they were exactly the same.

The way it worked is they would wire the DSH payment into our bank account and we had 15 minutes to turn around and wire it back to the state. So I believe they funded the first hospital, went through the transfer, second hospital, went through the transfer. So they are using one pot of money to recycle it all the way through so they could turn around to the federal government and receive their matching share.

THE COURT: And you're going to relate that to Medicaid.

MR. O'CONNELL: I'm going to relate that right now.

Q. Can you describe what Exhibit 93 is?

A. That is the history of the MET/DSH payments to the general fund.

Q. Now, the red line on the bottom is a net to hospital that you were just describing. That's flat from '93 until 2010, when it spikes up, and there is a net payment to the hospital; right?

A. That's correct.

Q. And then it drops to the floor?

A. That's correct.

Q. Now, that happens at the same time -- that gap happens at the same time the state makes the decision not to make UPL or DSH payments; isn't that true?

A. That's correct.

Q. So you have two things that are colliding that affect your bottom line at Frisbie and the other ten hospitals are having at the same time; isn't that true?

A. Yes, sir.

Q. You have a change of administration of a tax that used to be neutral that is no longer neutral; is that fair to say?

A. That's correct.

Q. And in fact in 2011 it actually got good for the hospital. There was a net payment from the state in UPL addition $8.2 million. And that's shown on Exhibit No. 93 where there's that little blip when things got better. True?

A. Yes, sir.

Q. And then in 2012 the bottom falls out of this; is that true?

A. Yes, sir.

Q. Now, that top blue line is the amount that has been moved to the general fund; isn't that true?

MS. LOMBARDI: Objection. I've let it go for a while, but it's getting very leading.

THE COURT: I'll take it as argument, but just inform me.

MR. O'CONNELL: I would say that the actual numbers are from state's Exhibit 49, and it shows that $1.8 million has been moved from 1991 to 2011 into the general fund.

THE COURT: The first numbers are actually I'm finding a little easier on the issue that I think we're here to decide, and so I mean -- I posit the following argument: The reduction in Medicaid rates that you're talking about don't give rise to any irreparable injury

here that would warrant injunctive relief. Why? Because that's not the reason that Medicaid services are being curtailed for Medicaid patients. The reason is because the state's decided to actually collect the tax and not rebate the amount of the tax to make it neutral. And what's your response to that?

MR. O'CONNELL: Yes, your Honor. Well, the response is that the state absolutely has the right to do that. It has to go through a public process getting state plan amendment on file where everyone has the opportunity to get their input in and file it and get it approved --

THE COURT: With respect to what? Not the tax. The DSH payment maybe.

MR. O'CONNELL: UPL, absolutely. UPL is a rate subsidy according to Mr. Lipman that is calculated on the amount of services that makes up the difference between what Medicaid pays and what Medicare pays.

THE COURT: All right. Go back and do that again.

MR. O'CONNELL: Yeah, sure. Mr. Lipman's testimony was that UPL is a form of rate enhancement. And the way it's calculated is that you are looking at the delta between what Medicaid would pay for the services and what Medicare would, and you can do the

enhancement up to what Medicare would pay. And that's how UPL is determined and it's paid. And the state offered a plan amendment that said we're going to pay this on an ongoing basis. Didn't do it for this year, and after they defunded it issued a state plan amendment. You're going to hear about that from the state witnesses. They did it after the fact. No public comment, no (30)(A) issues, no looking at the impact on patients by taking that money, which is rates, away. State says UPL is not rates. That's going to be a legal question for you to determine.

THE COURT: And the tax is not an issue then in your view.

MR. O'CONNELL: It's just a revenue impact. It's a historical anomaly that happens at the same time these are taken out. So I will say it this way. When you're trying to determine whether you're paying a fair wage to enlist enough providers to provide the services in the market, the 38 standard, you've got to look at the impact of your scheme on the providers. And the state never did a public process to look at the implementation of the MET that historically had been neutral in the change to say how is this going to affect the --

THE COURT: Why does the MET have to go

through that process? The MET is simply an imposition of a state tax.

MR. O'CONNELL: It's just a relevant issue as to what they have -- if they're going to have to pay that, it comes off the bottom line and they can't cross-subsidize, and they're going to take UPL out, well, then you have the circumstance --

THE COURT: You mean they have to consider it in the sense that they're deciding what the UPL will be --

MR. O'CONNELL: Yes.

THE COURT: -- and that's a function of that.

MR. O'CONNELL: It's a function of how they can afford to provide the services and is it sufficient to enlist enough providers to make it equal --

THE COURT: Because under the circumstances that we are going to now collect this tax, now the UPL looks different.

MR. O'CONNELL: Exactly right, thank you. It's relevant only in that respect, your Honor.

THE COURT: Appreciate it. Thank you.

MR. O'CONNELL: Exhibit 93 is taken from data that is a full exhibit, Exhibit 49, and I'd offer it at this time.

THE COURT: Any objection?

MS. LOMBARDI: Which exhibit?
MR. O'CONNELL: This is the graph.
MS. SMITH: There's been no foundation for it.
MS. LOMBARDI: Yeah, I object. This witness did not produce this. Foundation.
MR. O'CONNELL: The data is coming from the -- well, okay. That's fine. We'll use the state witness then. Thank you, your Honor.
THE COURT: Thank you.
MR. O'CONNELL: Nothing further from me, your Honor. Thank you.
THE COURT: Attorney Lombardi?

CROSS-EXAMINATION

BY MS. LOMBARDI:

Q. Hi, Mr. Marzinzik. I hope I got that right.
A. Yes, you did.
Q. If you could please turn to Plaintiffs' Exhibit 75. I think it might be up there with you?
A. Yes.
Q. You testified about that a few minutes ago?
A. Yes, I did.
Q. And that includes the upper payment limit that was just being discussed?
A. Um-hum.
Q. The 2010 payment of the upper payment -- the

upper payment limit payment made in 2010, is it your understanding that that was a one-time payment? It was intended as a one-time payment because the availability of RA funds that year?

A. No, my understanding was that that was something we were going to receive going forward. That's what the state plan amendment said.

Q. That's your understanding?

A. Um-hum.

Q. You also testified about your primary care offices instituting a seven percent cap on Medicaid patients?

A. We are allowing up to seven percent Medicaid patients in a physicians panel.

Q. And how are you going to track that, where Medicaid patients often go on and off of Medicaid?

A. It's just another bookkeeping situation that's been imposed on us that we will count. We have methodologies. We have a system already determined and set up to count patients by payer class. They will be reviewed monthly and they'll be turned on or off at the beginning of every month.

Q. In general, you do not expect to make a profit off of Medicaid patients; correct?

A. No, I do not. When they only pay 50 percent

of cost that would be quite a challenge.

Q. And in fact you lose more on Medicare patients; correct?

A. No.

Q. You do lose on Medicare patients though also; correct?

A. Are you talking inpatient, outpatient or physician practices?

Q. All of the above.

A. There are some situations depending on -- if you're talking annualized in a year, that would be a true statement. It comes close to covering costs on the physician side. On the inpatient/outpatient we do lose some margin on Medicare, that's true. Not to the extent that we lose on Medicare (sic), but it's quite a bit. The loss on Medicaid patients is quite a bit higher than we have in Medicare.

Q. But there are other areas that you have lost, not simply Medicaid?

A. True.

Q. And you testified about a number of changes that might occur in the future. Are you aware that managed care may be implemented?

A. And that's a problem, that's correct.

Q. But if managed care is implemented, then these

rates that we're discussing could change; correct?

A. Well, I have talked with six out of the seven companies that proposed -- that made a proposal to the state to be awarded the contract on receiving the Medicaid managed care program, of which they did not know what the rates were yet. I believe that the state put into their budget that they hope to save $16 million by outsourcing the Medicaid program to a Medicaid managed care program. And if they do that, my assumption is that we're not going to be paid more if the state is looking to save $16 million on top of what they're not funding today. That would be quite a trick.

Q. But you don't know at this point what changes will be made; correct?

A. No. I don't think the state does either.

Q. And your hospital is a member of the New Hampshire Hospital Association; correct?

A. Yes, it is.

Q. And they lobby on your behalf?

A. Yes, they do.

MS. LOMBARDI: I have no further questions.

THE COURT: Any redirect?

MR. O'CONNELL: I just need to correct the record, your Honor. I incorrectly referenced the source data in Exhibit 93 for ID is a graph, and the source

data is a full Exhibit, 45. We will take that up later.

THE COURT: Did we strike the ID on 75?

MS. O'CONNELL: If I didn't move to, I would like to move -- I think I did.

THE COURT: Any objection?

MS. LOMBARDI: Which exhibit?

THE COURT: 75.

MS. LOMBARDI: 75? No objection.

THE COURT: ID may be stricken on Plaintiffs' 75.

(Plaintiffs' Exhibit 75 admitted.)

MR. O'CONNELL: Nothing further.

THE COURT: Thank you, Mr. Marzinzik. You may step down. I appreciate it. You're excused. And you can call your next witness.

MR. MacDONALD: Your Honor, the plaintiffs call Kathleen Dunn.

KATHLEEN DUNN

having been duly sworn, testified as follows:

THE CLERK: Would you please state your name and spell your last name for the record.

THE WITNESS: Kathleen Dunn, D U N N.

DIRECT EXAMINATION

BY MR. MacDONALD:

Q. Ms. Dunn, good afternoon. My name is Gordon

MacDonald. I represent the plaintiffs in this lawsuit. Could you please tell the Court your current job? Where do you work?

A. I work for the Department of Health and Human Services for the State of New Hampshire. I'm the director of the office of Medicaid business and policy.

Q. And you're the state Medicaid director; is that correct?

A. I'm the designated state Medicaid director.

Q. And how long have you been the state Medicaid director?

A. Since 2007.

Q. And what are your duties as state Medicaid director?

A. I oversee a portion of the Medicaid program, predominantly all acute care services, services that are not long-term care related, and within that I'm responsible for preparing budget documents, preparing policy documents, dealing with client service issues, etc.

Q. How long have you been employed at the Department of Health and Human Services?

A. 18 years.

Q. And how long have you been involved in the Medicaid program?

A. On and off since the late nineties.
Q. And I understand you're a nurse by training; is that correct?
A. I am.
Q. As part of your duties as the state Medicaid director, do you interact with the state legislature?
A. I do.
Q. And do you prepare testimony and testify before the state legislature?
A. I do.
Q. I'd like to show you what's been marked as Exhibit 49.
MR. MacDONALD: May I, your Honor?
THE COURT: Anytime.
Q. Exhibit 49 appears to be a special -- or Powerpoint presentation that was made to the senate in April of 2011; is that right?
A. That's correct.
Q. And is this a document that you helped prepare?
A. Yes, it is.
Q. And did you give testimony before the senate on or about April 7, 2001?
A. Yes, I did.
Q. Okay. We've reproduced two of the slides from

your testimony, and I'd like to have you either join with me up here or look at the document in front of you. Start with page 13. And this is a page -- did you prepare this page?

A. I did.

Q. And it is a page describing Medicaid provider reimbursement rate setting and it lists some requirements under a regulation, 42 CFR 447.252, and it says that state plan includes -- include description of the methods and standards used to set payment rates. And is that your testimony today about what a state plan must include?

A. Methods and standards, yes.

Q. And the state plan must allow parties to understand the rate setting process, the items and services that are paid through these rates; is that correct?

A. Yes, it is.

Q. And it must describe how the state's share of each type of payment is funded; is that correct?

A. Yes, it is.

Q. And you say there, e.g., legislative appropriation. What do you mean by that?

A. Giving an example of the type of funding that the -- concerned as to the state match to the federal

matching dollars.

Q. Then it says Section 1902(a)(30), and we've been using the reverse here, (30)(A), requires payments for services to be consistent with efficiency, economy, and quality of care. And you understand that to be the obligation of the state in reimbursing providers, don't you?

A. Yes, I do.

Q. Okay. The state plan must include a detailed description of the calculation of upper payment limits; isn't that correct?

A. Yes, it is.

Q. And finally, Section 1902(a)(2) of SSA -- which is the Social Security Act; is that correct?

A. Yes, it is.

Q. Which authorizes the Medicaid program, provides that the lack of adequate funds from state and local resources will not result in lowering the amount, duration, scope or quality of care, and service available. And you understand that to be the obligation of the state, don't you?

A. Yes, I do.

Q. The next page, page 14, captioned, "Medicaid Rate Reductions." And it says that state plan amendments for rate reductions. Is a state plan

amendment required for a rate reduction?

A. No, it is not.

Q. When is a state plan amendment required?

A. When you are changing the methodology that you are utilizing to make a payment, if you are changing criteria or standards for a provider type, if you are adding or eliminating a benefit. Those are examples.

Q. If you're changing the methodology that the state is using to pay providers, that requires a state plan amendment, doesn't it?

A. The methodology, yes.

Q. While we're on the subject of plan amendments, I'd like to show you what's been marked as Plaintiffs' 3. I believe it's a full exhibit. And I'd like to ask you to take a look at the second page of that exhibit. Do you recognize that document?

A. Yes, I do.

Q. And is that part of the New Hampshire state plan?

A. Yes, it is.

Q. Let's just orient ourselves on what the state plan is and what it looks like, if you will. Let's go to the bottom of the document and start on the left-hand side, and it says TN Number. T N, N O, period. Do you see that?

A. Yes, I do.
Q. And that stands for transmittal number; is that correct?
A. That's correct.
Q. And that transmittal number is the number assigned by the state when it submits a state plan amendment to CMS; is that correct?
A. That's correct.
Q. Okay. And below that it says: Supersedes TN number, in this instance, 90-11. So that this document supersedes a prior version of this part of the state plan; is that correct?
A. That is correct.
Q. And then back to the transmittal numbers, that first digit I assume represents the year in which the transmission is made?
A. Yes, it is.
Q. In other words, in this case 1991, and then the number's assigned, the number of the transmission in that year; is that correct?
A. Yes, it is.
Q. Okay. Then moving in the middle there is an approval date, and in this instance it looks like it's November 27th, 1992; is that right?
A. That's what it says, yes.

Q. Okay. And the approval date means the date on which CMS approved the state plan amendment; is that correct?

A. That's correct.

Q. All right. And then on the right-hand side is the effective date, and in this instance it's November 1st, '91; correct?

A. That is correct.

Q. And the effective date is something that the state asks for when it submits a state plan amendment; correct?

A. That is correct.

Q. Now, let's go to the substance of this particular plan amendment. And it says that the plan will be amended whenever necessary to reflect new or revised federal statutes or regulations or material change in state law, organization, policy, or state agency operation; is that correct?

A. That is correct.

Q. And that is the state's obligation in terms of when it needs to amend the state plan; correct?

A. This is the page that speaks specifically to plan amendments. I can't speak to whether there aren't other parts of the state plan that also have information regarding plan amendments.

Q. Okay. But you'd agree with me, wouldn't you, that whenever there's a material change in state law, the state needs to submit -- affecting the Medicaid program, the state needs to submit a state plan amendment; isn't that correct?

A. For a material change in state law, yes.

Q. Okay. Back to page 14 of your April testimony. Public process requirements. There is a requirement under the state plan that there be a public process associated with rate changes; isn't that correct?

A. No, that is not correct.

Q. Okay.

A. If the state plan amendment is submitted, there is a public process. The rate change does not necessarily mean that you will be submitting -- the state will be submitting a state plan amendment.

Q. Is there a public -- requirement for a public process associated with rate changes?

A. Yes.

THE COURT: He doesn't mean a plan amendment, he means a public process.

A. Yes, there is.

Q. Okay. Let's take a look at Plaintiffs' No. 7, which actually was an exhibit to your affidavit. I

believe it's a full exhibit. Ms. Dunn, do you recognize this document?

A. Yes, I do.

Q. It's a letter from Sally K. Richardson, the director of CMS, and it's dated December 10th, 1997, and it appears that it was issued immediately after the repeal of the Borring (ph.) amendment, and when the requirements of what's known as Section (13)(A) of the Medicaid Act came into effect. Would you agree with that?

A. Yes, I would.

Q. Okay. Let's take a look at the second paragraph of this letter from Ms. Richardson, and it describes what is required under Section (13)(A). States must use a public process for determining rates. States must publish the proposed and final rates, the methodologies underlying the rates, the justification for the rate. It must give interested parties a reasonable opportunity to review and comment on the rates, methodologies and justifications, and the rates must take into account the situation of disproportionate share hospitals. Do you understand that to be the obligation of the state with respect to Section (13)(A)?

A. I understand that that is the obligation as outlined in this letter.

Q. Okay. Let's take a look at the next paragraph, please. And I want to pick up on the second sentence of that letter. It says HCFA -- and HCFA I think we can agree is the predecessor agency to CMS; is that right?

A. Yes.

Q. Okay. HCFA would consider the state to be in compliance with this provision if it elected to use a general administrative process similar to the federal Administrative Procedure Act that satisfies the requirements for public process in developing and inviting comments.

Now, Ms. Dunn, I hope we can agree that by statute New Hampshire, or the legislature by statute, has exempted Medicaid rates from the state Administrative Procedure Act; isn't that correct?

A. Could you please restate that?

Q. Sure. There is a statute which -- let me ask you this way.

THE COURT: Well, it's a question of law and I understand that to be the case.

MR. MacDONALD: Okay.

Q. Is rate making subject to the state Administrative Procedure Act?

A. I'm sorry, I'm not able to answer that

question.

THE COURT: It's no.

MR. MacDONALD: Thank you, your Honor.

Q. So in the instance that it is not, the letter goes on to say that if -- this is the last line in the third paragraph. If a state public process is not currently being applied to rate setting or does not currently include a comment period, then the rate -- the state would need to modify the process. Do you see that?

A. Yes, I see it.

Q. And then it turns you to enclosure two for public process options, which are the options endorsed by CMS. And enclosure two appears on the bottom of page 2 of this exhibit. Are you with me?

A. Yes, I am.

Q. Okay. Let's just go through it. States that do not use their existing administrative procedures to satisfy the public process requirement may use at their option one of the public processes established in the Federal Register. It goes on, this allows the states flexibility to design public process based on examples of what we find acceptable. Options which HCFA considers acceptable and which states may elect to choose include four options.

Now, my question to you is on option one, does the Department of Health and Human Services of the State of New Hampshire hold one or more public hearings at which proposed rates, methodologies, and justifications are described and made available to the public and time is provided during which comments can be received? Does it hold one or more additional public hearings in which final rates, methodologies, and justifications are described and made available to the public? My question is whether the department has a procedure similar to option one, and I believe the answer is no; isn't that right?

A. The answer is yes relative to submitting state plan amendments. In terms of rates, we need to go through each individual rate so that I could respond appropriately.

Q. So your testimony is that there's a public process whereby a state plan amendment is proposed and the Department of Health and Human Services holds a hearing?

A. For state plan amendments, it depends on the particular state plan amendment. Our state plan does not specify what that public process is. In fact, CMS has reinforced recently that they have allowed the states to have flexibility in determining that. In the

past --

THE COURT: Just so I don't get confused, and we have a finite amount of time in our lives, I think what he's driving at is with respect to the rate reductions, was there some process that was followed that you're aware of? Some public process, any public process --

THE WITNESS: Yes, your Honor.

THE COURT: Can you tell me what it was?

THE WITNESS: Yes, your Honor.

THE COURT: What is it? What was it?

THE WITNESS: Again, going through each of the --

THE COURT: Take one and just give me an example. What was the rate reduction, what was the process. Do you mind? I know you mind, but I want to cut through it.

THE WITNESS: So you take, for instance, the November 2008 patient reduction, that was actually a rate reduction that had been started -- have conversations about back in the beginning of 2008. There was an exchange of information and letters between the department and the New Hampshire Hospital Association. The Hospital Association had suggested alternative methods to achieving the savings. That item

-- so that happened in February.

In April we brought forward a fiscal committee item to the Joint Legislative Fiscal Committee. That hearing took place, at which time the item was tabled by the legislators because they wanted the department to go back and try to work with the hospitals, again, to come up with a plan to not have to do the outpatient hospital rate reductions. There were subsequent conversations between Commissioner Toumpas, the governor, and representatives from the Hospital Association.

When the -- at that point -- as we got into the late summer it became clear that there wasn't going to be a resolution. So we put forward a fiscal item that was heard on November 21st. Prior to that item going forward, we had communicated with the Hospital Association, who historically has always represented the individual hospitals, to confirm what the reduction was going to encompass and how much it was going to be, given that the item had been delayed from April to November.

We then held -- the fiscal meeting was held. There was a lot of conversation about -- questions around rate setting and access. The item was approved.

Following that we published what they call remittance advices. It's on the -- like the check that

goes to the hospital. It's the remittance, and there's almost like an explanation of benefits on the top of it. We also sent -- I also signed individual letters to every hospital notifying them of what their rate -- their new rate was going to be under that reduction.

THE COURT: I'm sorry. Thank you.

Q. MR. MacDONALD: What is the process?

A. Pardon me?

Q. What is the department's process?

A. For what, sir?

Q. For rates. You have an obligation under Section (13)(A) to have a public process. Where is the process that you have in place published?

A. The rate changes generally are or have been associated with a legislative change.

Q. I'm sorry. I'm asking about the existence of a public process. And it is a fact, isn't it, that there is no written public process which the department has which purports to comply with Section (13)(A); isn't that correct?

A. No, I don't agree with you.

Q. What is the -- where --

A. There is no requirement for us within our Medicaid state plan to specify what the public process will be.

Q. Okay. Does the department use a commission or similar process in determining rates where meetings are open to the public and final rates, methodologies, and justifications are made available? That's option two from the CMS.

A. We have used that and we've used it recently.

Q. You haven't used it in any of the rates at issue in this case; isn't that correct?

A. I'm sorry. I don't agree with you, sir. We had a group, a commission, it wasn't an official commission, but it was a group that had legislators and hospitals for the 2010 DSH program redesign.

Q. Do you include a notice of intent to submit a state plan amendment in newspapers of general circulation and provide a mechanism for members of the public to receive a copy of the proposed and final rates, methodologies, and justifications underlying the amendment and an opportunity which shall not be less than 30 days prior to the effective date to comment on the proposed rates, methodologies, and justifications?

A. If we are submitting a state plan amendment, we do follow this.

Q. You allow a comment period of no less than 30 days prior to the effective rate. That is your testimony?

A. To the proposed effective date.

Q. Okay. Now, the long answer you gave to the Court related to a budget -- a rate cut which took place in November of 2008; isn't that right?

A. It was approved in November of 2008.

Q. Okay. And that cut that you described, or the process if you will that you described, related to a cut of outpatient rates from 81.24 percent to 54.04 percent of allowable costs for non-critical access hospitals; isn't that correct?

A. That is correct.

Q. And the rate cut was submitted to the Joint Fiscal Committee on or about October 30, 2008; isn't that right?

A. The item was -- submitted back in April of 2008 was tabled.

Q. The item to cut to 54.04 percent?

A. No, sir. It was the item to reduce the rate, which at that time would have only had to have been reduced to I believe 62 percent.

Q. Okay. So the April rate was only to 62 percent, and the October rate cut which was eventually approved was to 54.04 percent; isn't that right?

A. That is correct.

Q. And those are two different rate cuts; isn't that correct?

A. They are the same rate cut that had to be adjusted because of the delay between July 1 until the November fiscal item was approved.

Q. The first rate cut was never approved; isn't that correct?

A. It was tabled.

Q. I'd like to show you Exhibit 16. Exhibit 16 appears to be a letter dated October 30, 2008, to Representative Smith, who I think we can agree was the chairman of the Joint Fiscal Committee at that time; is that correct?

A. That's correct.

Q. And it appears that you -- your name is at the end of the letter. I'm not sure you signed it. But did you review and approve of this letter?

A. Yes, I did.

Q. Okay. And on page 1 of the letter it recites RSA 126-A:3 VII, and it was pursuant to that statute that you were presenting this rate cut; isn't that correct?

A. That is correct.

Q. Then page 2, first paragraph of text, second sentence, you are telling the committee that the cut is

required to bring expected expenditures in line with the appropriations for SFY 2009. The department proposes to reduce payments for hospital outpatient services by 33.48 percent, from the current 81.24 for Medicare allowable costs to 54.04 percent of Medicare allowable costs for non-critical access hospitals effective retroactive to July 1st, 2008.

And the committee took up this proposal, and I'd like to show you the testimony. This rate cut was to bring the amount that the department was going to spend on outpatient rates in line with the amount that had been appropriated; isn't that correct?

A. It was done to bring in line what we had projected for a total expenditure for that year.

Q. It was to meet the requirements of your budget; isn't that correct?

A. Yes, and to meet the state law.

Q. Exhibit --

THE COURT: The rate was set to basically work out to equal the amount of money available to you.

THE WITNESS: That's correct, your Honor.

Q. Exhibit 23 is the transcript of the hearing. And you appeared and testified; is that correct?

A. I believe, yes, I did, with Commissioner Toumpas.

Q. And page 38, this is exactly the point the Court just made. You had a colloquy with Senator Kelly and -- bottom third of the page, Senator Kelly: You made a decision on that particular amount, that percentage, so that you would balance the budget on that line item. And then you answered: That is correct. And that's what happened; isn't that right?

A. That is what I answered, yes.

Q. And you yourself --

THE COURT: But is that in your view what happened as well? I know it's what you answered, but the question is, is that really what happened?

THE WITNESS: Yes, with the understanding that when balancing the budget, it wasn't for the entire budget, sir. It was specific to outpatient hospital line in the budget that has its own separate line. I didn't want to confuse --

THE COURT: For Medicaid outpatient care?

THE WITNESS: Yes.

THE COURT: Okay.

Q. Now, you viewed these cuts as drastic, didn't you?

A. I believe that that's what my testimony speaks to.

Q. You told the Joint Fiscal Committee that they

were drastic, and these cuts did not comply with the state's obligation under Section (30)(A), did they?

A. I'm not sure I used the word drastic, first of all. And in terms of complying with (30)(A), we followed the exact same procedure that we had followed -- or the state followed in 2005 when there was a previous rate reduction to hospital outpatient services. There was no state plan amendment filed. The rate reduction went through the exact same process that this one did. I was not there, so -- I was not the Medicaid director, so I can't speak to who testified about the impact of it.

And so my point is, sir, I'm trying to say we followed the exact same process we followed in '05 and did not receive to my knowledge any feedback, concern voiced, letters, emails, phone calls that I'm aware of from individual hospitals or the Hospital Association saying that they didn't agree with how the 2005 cut was implemented. Consistent with that, we followed the same procedure in '08.

Q. Let's just -- so we're all on the same page and we understand what's going on, the statute at issue, 1206-A:3 VII was enacted in 2005. Can we agree to that?

A. I would have to -- if it's a fact I'll agree to it, but I don't have that in front of me.

Q. But in 2005 there was a prior across-the-board rate reduction effected under that statute which brought the Medicaid outpatient rates for non-critical access hospitals from 91.27 percent down to 81 percent; isn't that right?

A. Down to 84 and, sir, it does say in here July 1, 2005.

Q. Okay. Now, let's go back to the 2008 rate reductions. These were effected because -- effected under this statute, as we've already established, and the state did not go through any process to determine how the revised, reduced rates will comply with its obligations under Section (30)(A); isn't that correct?

A. I'm sorry, sir, could you restate that?

Q. Sure. Prior to the rate reductions approved by the Joint Fiscal Committee on November 21st, 2008, effective retroactive to July 1st, 2008, the state didn't do any analysis about how that rate reduction would impact its obligation under Section (30)(A) in terms of providing for consistent -- I'm sorry, efficiency, economy, and quality of care, and access to care; isn't that correct?

A. There was no specific study completed that I'm aware of.

Q. Okay. And just on the point of your

characterization of the rates, I just turn you on page 23 -- Exhibit 23, I'm sorry, page 48. You had a colloquy with Representative Kirk and you were answering his question, and it's your first answer on that page. I believe that is what should happen because of the sensitivity around the fact that we are drastically reducing outpatient hospital rates. Isn't that what you told Representative Kirk?

A. Yes. Thank you for refreshing my memory.

Q. You're welcome. The commissioner also appeared and testified with you, and I'd like to direct your attention to page 54 of the testimony. And it's a colloquy that Commissioner Toumpas had with Representative Kirk. Representative Kirk -- I'm not going to read the whole thing, but at the end of his statement he asks -- he says, quote, but there is another way. The hospitals could absorb this out of their surplus. So the question I'm asking is, do we know if the hospitals have sufficient surplus to absorb this kind of cut, or will they in fact have to cost shift it just to maintain, at least for the nonprofit corporations, at least to break-even financial position? And the commissioner answered that you did not have access to the data on hospital finances; isn't that correct?

A. He states that we did not have the projections on a hospital by hospital basis in terms of what it would mean to their operating margin in the past year. That's correct, we do not have access to that information.

Q. And you didn't consider it, therefore, in recommending this across-the-board 33 percent cut; isn't that right?

A. No, we considered the information that we were able to understand from an October 2008 report that was presented publicly that was commissioned by the Endowment for Health and looked at the financial health of the hospital network in New Hampshire, individual hospitals as well, by Dr. Nancy Kane.

Q. You were obligated under the statute to make an across-the-board cut, isn't that correct, regardless of whatever the Kane report said?

A. We were obligated to bring the item forward for rate reduction, yes, sir.

Q. Okay. Now, there was no public notice of the state's reduction of rates down to 54.04 percent 30 days prior to their effective date which was July 1st, 2008, was there?

A. That would depend on how you define public notice, sir, and I'm not trying to be flip. There have

been conversations going on from the beginning of January 2008 with the Hospital Association about what the issue was, what the numbers look like, and there was exchanges of letters both back and forth between the department, and also the Hospital Association, with the Governor's Office as well.

Q. I'm asking about the rate reduction to 54.04 percent. There was no public notice that the state was going to reduce the outpatient rates to that level 30 days prior to July 1st, 2008, was there?

A. The hospitals knew about this back at the beginning of the year. You're asking if we held a specific public hearing. No, we go through the Joint Legislative Fiscal Committee hearing process and that's what we did, sir.

Q. And let me -- you didn't know until October, thereabouts, that you'd need to cut the rates down to 54.04 percent; isn't that right?

A. No, we knew that there was going to be a deficit. Right after the beginning of every calendar year, so January, we project out all of our costs through the end of the fiscal year, which goes through June 30th. In January it was already apparent that there was going to be a deficit in that particular line item, plus others that have nothing to do with the

hospitals. At that point there started the exchange of ideas for how to close that gap between the department, the governor, and the Hospital Association.

Q. Well, I'm going to ask this one more time. The specific rate cut that the joint legislative committee approved on November 21, 2008, was not subject of a public notice 30 days prior to its effective date; isn't that correct?

A. Based on how you've asked the question, the answer is yes.

Q. Now, I'd like you to again on the testimony flip back to page 47. Okay. Middle of the page as it's on the screen, again another colloquy with Representative Kirk. He says: Follow-up of an additional question. The statutory requirement in the budget if there isn't enough money to pay the bill, you cut back on the rate. It's what's another version of what we call budget neutrality. Is that something that requires modification to the state plan, and if so, has that been obtained? To which you respond: It does not require state plan amendment.

Now, that was not a correct answer, was it?

A. I don't agree with that, what you just said. It was a correct answer. It did not require a state plan amendment. In subsequent conversations, both

letters exchanged between the Hospital Association and CMS and our follow-up with CMS, there was no request to file a state plan amendment by our federal officials.

Q. I'm going to show you Exhibit 2. Now, Exhibit 2 was submitted in this case as part of an affidavit by one of your colleagues, Diane Peterson. And it is, as I understand it, a compendium of state plan amendment pages relating to outpatient services. Would you agree with that?

A. That's what it looks to be, yes, sir.

Q. Okay. Could you please turn to the page, the approved state -- the approved page pending -- strike that. To the page governing outpatient reimbursement which had been approved by CMS as of November 21st, 2008, and just tell me what page you land on.

A. For the outpatient rate reduction?

Q. Yes.

A. We didn't submit a state plan amendment for that rate reduction.

Q. What was the methodology in effect at the time the 2008 outpatient rate reductions were in effect?

A. The methodology for what, sir?

Q. Setting outpatient rates.

A. For setting outpatient rates? The rates were set based upon -- I'm not sure if you're asking me to

talk about how cost rates reimbursement and how all that happens.

Q. No. I'm asking you, as the state Medicaid director, to point to me in the state plan where the methodology exists as of November 21st, 2008, in terms of setting outpatient reimbursement rates.

A. The last approved page that I see in this packet --

THE COURT: No, he's saying if I wanted to look at this and say what method do you use to set outpatient reimbursement rates, what method would I find? What does it say? How do you go about doing that?

MR. MacDONALD: May I, your Honor. Had CMS approved at the time they made these rate reductions --

THE WITNESS: The rates were set based upon the funding that was available --

THE COURT: This isn't my field and I'm easily confused.

THE WITNESS: Yeah. I am, too.

THE COURT: So what he's really asking, what I'd be interested in, too, is show us where the approved methodology is in that plan for setting the rates as of November 21, 2008. What is it, where is it, how do I see that? I ask myself, gee, what's the methodology for

setting outpatient Medicaid reimbursement rate within the state plan as of November 21, 2008. What do I read that's going to tell me what that methodology is?

THE WITNESS: Looking at the last page that was approved, sir, I don't see it specifically spelled out.

THE COURT: There is no methodology in the state plan?

THE WITNESS: It talks about the interim payments that we make to the hospitals and how we do retrospective cost based reimbursement based upon --

THE COURT: But I'm a provider and I want to know how you're going to set the rate. And you agree you have to put in the plan the methodology for setting the rate, right, so I know what it is?

THE WITNESS: Yes, you're right.

THE COURT: I wouldn't find it in the state plan?

THE WITNESS: You wouldn't find it on the last approved state plan page that CMS approved.

THE COURT: I have no idea what that means.

THE WITNESS: It means that the last time CMS looked at this page and approved it, it was not contained within this particular page. It means that there is a subsequent state plan amendment where further

clarification can and is made relative to methodology.

MR. MACDONALD: May I, your Honor?

THE COURT: Please.

Q. BY MR. MACDONALD: Let's just take this one step at a time, and it is confusing. Could you identify for the Court the page that CMS had approved governing outpatient reimbursement methodology as of November 21st, 2008.

A. It would be what is labeled at the top as page 6 of 57 of Plaintiffs' Exhibit 2. I believe at the bottom it says that the last transmittal number that was approved was 87-7 and that there was a pending state plan amendment that had been submitted. So 87-7, that means it was 1987.

Q. I'm looking for the page that says approved, not one that's pending.

A. Then you have to turn to the page before then.

Q. Okay. And let's take a look at that page. And just so we're all on the same page so to speak, let's go down to the bottom of the page and again starting on the left, it's transmission number 87-7; is that correct?

A. Yes, sir.

Q. And that had been approved on November 5th, 1987?

A. That's correct.
Q. And it had an effective date of July 1st, 1987?
A. That's what it says, yes.
Q. Okay. Now, let's go to the paragraph marked outpatient hospital services. And for the Court's benefit, would you agree that that was the approved methodology in place at the time of the 33 percent rate reduction?
A. Yes, it seems to be the approved page.
Q. And you would agree with me that that methodology does not support an across-the-board 33 percent rate reduction; isn't that right?
A. Well, sir, it says -- I don't want to read what it says here, but it reads to me that payment will be made at the lowest charge determined, and it goes on and then it ends with the lowest charge level determined by the Title 19 state agency, which is the Department of Health and Human Services. That's how it was interpreted.
Q. Let's start at the beginning. Payment is made in accordance with the methods and principles developed for reimbursement in such services for hospitals participating in Title 18 of the Social Security Act. And that refers to Medicare, doesn't it?

A. It does.
Q. And how are Medicare hospitals compensated?
A. I can't answer that, sir, I'm sorry.
Q. On certain medical services and supplies designated by the secretary of Health and Human Services -- we don't have secretaries in New Hampshire, do we?
A. No, we do not.
Q. Payment will be made at the lowest cost charge level determined by the Title 18 agency for Medicare covered services, and for Medicaid covered services the lowest charge level determined by the Title 19 state agency.
That language does not support a reimbursement methodology where the director of the state Medicaid program can come into the Joint Legislative Fiscal Committee and recommend an across-the-board budget cut, does it?
A. Sir, you're asking me to compare this legal language -- the state plan language along with the state law, and I don't feel that I'm prepared to do that.
Q. Okay. But there's another complication to this --
MR. MacDONALD: And I'm sorry, your Honor, but -- it's a bit complicated, but it's actually important.
THE COURT: Can you do it in five minutes?

MR. MacDONALD: I'll try.

THE COURT: Well, we have our own budget problems in the federal government and we have committed to the United States Marshal that we would not carry proceedings up to or beyond 5 o'clock because then he has to pay overtime to the court security officers and he runs afoul of his own budget restraints, so we're kind of limited. Do you want to do it tomorrow?

MR. MACDONALD: Take a break.

THE COURT: All right. Why don't we adjourn till tomorrow morning. Is the schedule for 9:30? 9 o'clock all right?

MR. O'CONNELL: Yes, your Honor.

THE COURT: Why don't we do 9 o'clock. Thank you.

(Adjourned at 4:45 p.m.)

C E R T I F I C A T E

I, Diane M. Churas, do hereby certify that the foregoing transcript is a true and accurate transcription of the within proceedings, to the best of my knowledge, skil

Submitted: 1/27/1

DIANE M. CHURAS, LCR, CM
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